LETTERS TO THE EDITOR

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

BREAST FEEDING AND JAUNDICE

To the Editor:

In their article on breast feeding and jaundice (*Johnson CA, Lieberman B, Hassanein RE: The relationship of breast feeding to third-day bilirubin levels. J Fam Pract 1985; 20:147-152*), Drs. Johnson, Lieberman, and Hassanein came to the conclusion that ". . . breast-feeding infants . . . have higher bilirubin levels than formula-fed infants on the third day of life. . . ." I think this conclusion should be amended to include the following phrase: "when kept in the hospital until the third day."

Although I can only bring anecdotal evidence to bear on this question, I think a major flaw in their study is that a separate group of early discharged or not hospitalized patients was not included. I currently have a practice where 95 percent of my patients breast feed, most of them exclusively. Most of these patients were either born at home or were discharged early from the hospital at 12 to 24 hours of age. I find a significant difference (and again this is anecdotal) between these babies and babies left in the hospital for more than 24 hours as far as the ease in initiating breast feeding. The reason for this, I believe, is that hospital routines, even with rooming in, are not conducive to the initiation of good breast feeding.

As an example, nurses, as well meaning as they may be, cannot always bring the infant immediately when he or she is crying. This can cause the infant to be frustrated and can result in some early feeding problems. Nurses in the nursery and nurses on the obstetric floor will often give conflicting or outdated advice, which also may interfere with successful lactation. I find that infants who spend less than 24 hours in the hospital have less weight loss, less nursing problems, and less problem with bilirubin on the third day of life.

I would wonder whether the authors of the article would have in fact found a significant difference between breast- and formula-fed infants had they included an early discharge or home delivery group in the statistics.

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SOMATIZATION AND ALEXITHYMIA

To the Editor:

In Robert Smith's article, "A Clinical Approach to the Somatizing Patient" (*J Fam Pract 1985; 21:294-301*), a valuable concept was ignored in his discussion of this important issue. The last part of his article deals with countertransference in somatizing patients. This is an interesting concept from a psychiatric point of view, but it actually views the problem of somatization along an obsolete paradigm.

A more useful way of viewing the problem of the patient-physician relationship in somatization is through the concept of alexithymia[1] on the part of the patient rather than countertransference in the patient-physician relationship. In

some preliminary research in this area, it can be shown that a common problem in somatizing patients has to do with their degree of alexithymia, that is, their inability to verbalize affect and to elaborate fantasies. These patients are unable to state that they have depression, for instance, because they are unable to conceive of the notion. They do feel bad, however, and are able to present multiple symptoms to the physician, who is then frustrated that there are no objective physical findings.

A useful therapeutic approach based on this paradigm, then, is to attempt to "move away" from the patient's symptoms and to begin dealing with the historical and contextual events in the patient's life, as described by Katon (*Katon W: Somatization in primary care. J Fam Pract 1985; 21:257-258*), which are invariably present.

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Reference

1. Taylor, GJ: Alexithymia: Concept, measurement, and implications for treatment. Am J Psychiatry 1984; 6:141

The preceding letter was referred to Dr. Smith, who responds as follows:

While alexithymia is a fascinating concept of potential heuristic and descriptive value, a reliable and externally validated instrument to measure it has not been developed.[1] Although the lack of such an instrument does not distinguish alexithymia from most of the common somatizing disorders,[2] the latter are accepted in psychiatry and included in DSM-III. My reason for ignoring alexithymia is that the diagnosis of somatizing patients is already confusing to nonpsychiatrists, and to add another entity with little or no validation seems counterproductive. My point was in the opposite direction: to avoid diagnostic confusion by using a simple descriptive term (common somatization syndrome) until more precise diagnostic entities can be reliably defined and validated and shown to be understandable and usable in primary care, where most of the patients are seen. Alexithymia, somatization disorder, hypochondriasis, and psychogenic pain may be useful constructs and are prime candidates for rigorous study, well exemplified in the work of Woodruff and associates.[3] Until such study clarifies the diagnostic confusion, however, we can be content with the simple descriptive diagnosis (common somatizer) in primary care because the treatment for the various proposed diagnoses is essentially the same, always including a major emphasis upon the physician-patient relationship.

Dr. Troncale's assertion that countertransference is an obsolete concept is puzzling in view of the central role of the physician-patient relationship in managing somatizing patients. To focus upon the patient to the exclusion of countertransference overlooks many attitudes of physicians that can seriously interfere with developing a therapeutic relationship. Perhaps I have misunderstood Dr. Troncale because the reference he cites emphasizes the important role of countertransference and because, as I recommended, I agree with his final idea, ie, to avoid reinforcing somatization while attempting to shift the focus to stressful life events.

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References

1. Lesser IM: A review of the alexithymia concept. Psychosom Med 1981; 43:531-543
2. Hyler SE, Sussman N: Somatoform disorders: Before and after DSM-III. Hosp Community Psychiatry 1984; 35: 469-478
3. Woodruff RA, Goodwin DW, Guze SB: Psychiatric Diagnosis. New York, Oxford University Press, 1974, pp 58-74